DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 03-01	2. STATE Louisiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2003	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.252	a. FFY 2003 ($499.22) b. FFY 2004 ($867.71)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 4.19D Page 9.I	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) TN 00-30
Attachment 4.19-D, Pages 2, 3, 4, 5, 6	Same (TN 96-34)
Attachment 4.19-D, Page 7	Same (TN 01-07)
Attachment 4.19-D, Page 8	Same (TN 96-34)
Attachment 4.19-D, Page 9	Same (TN 01-14)
Attachment 4.19-D, Page 9.a.	Same (TN 00-46)
Attachment 4.19-D, Page 9.b.	Same (TN 99-04)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to establish a system of prospective payment for nursing facilities based on recipient care needs that incorporates acuity measurements as determined under the Resource Utilization Group III (RUG-III) resident classification methodology.**

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

■ OTHER, AS SPECIFIED: **The Governor does not review state plan material**

12. SIGNATURE OF STATE AGENCY OFFICIAL: David W Hood	16. RETURN TO:
13. TYPED NAME: David W. Hood	State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030
14. TITLE: Secretary	
15. DATE SUBMITTED: March 26, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 26 2003	18. DATE APPROVED: JUN 28 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Charlene Brown for Smith.
21. TYPED NAME: Charlene Brown	22. TITLE: Deputy Director CMSO

23. REMARKS Per verbal change to block # 8 and block # 9

FORM HCFA-179 (07-92)

I. METHOD FOR REIMBURSEMENT TO NURSING FACILITIES

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing establishes a system of prospective payment for nursing facilities based on recipient care needs that incorporates acuity measurements as determined under the Resource Utilization Group III (RUG-III) resident classification methodology. This system establishes a facility specific price for the Medicaid nursing facility residents served. It also provides for enhanced reimbursement for Medicaid residents who require skilled nursing services for an infectious disease and technology dependent care. Facilities may furnish any or all of these levels of care to residents. Every nursing facility must meet the requirements for participation in the Medicaid Program.

A. COST REPORTS

1. Nursing facility providers under Title XIX are required to file annual cost reports as follows.

    a. Providers of nursing facility level of care are required to report all reasonable and allowable cost on a regular nursing facility cost report. Effective for periods ending on or after June 30, 2002, the regular nursing facility cost report will be the skilled nursing facility cost report adopted by the Medicare Program. This cost report is frequently referred to as the Health Care Financing Administration (HCFA) 2540.

    b. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the Bureau.

    c. Providers of skilled nursing-infectious disease (SN-ID) and skilled nursing-technology dependent care (SN-TDC) services must file additional supplemental schedules designated by the Bureau documenting the incremental cost of providing SN-ID and SN-TDC services to Medicaid recipients.

    d. Separate cost reports must be submitted by central/home offices when the costs of the central/home office are reported in the facility's cost report.

2. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and non allowable cost contained in the Medicare/Medicaid provider reimbursement manual, with the following exceptions.

    a. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

    b. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the Medicaid Program prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for

situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

B. NEW FACILITIES AND CHANGES OF OWNERSHIP OF EXISTING FACILITIES

1. New facilities are those entities whose beds have not previously been licensed and certified to participate in the Medicaid program. New facilities will be reimbursed using the statewide average case mix index to adjust the statewide direct care and care related price and the statewide direct care and care related floor. After the first full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with section C.2.d.i.(6)-(7) and section C.3. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the actual capital rate for the new facility is determined.

2. A change of ownership exists if the beds of the new owner have previously been licensed and certified to participate in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity and capital data of the prior owner. The new owner's acuity and capital data will be used to determine the facility's rate following the procedures specified in section C.2.d.iii.

C. REIMBURSEMENT TO PRIVATE AND NON-STATE GOVERNMENT OWNED OR OPERATED NURSING FACILITIES

1. Definitions

   a. **Administrative and Operating Cost Component** — the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

   b. **Base Resident-Weighted Median Costs and Prices** the resident-weighted median costs and prices calculated in accordance with section C.2. during rebase years.

   c. **Calendar Quarter** — a three-month period beginning January 1, April 1, July 1, or October 1.

   d. **Capital Cost Component** — the portion of the Medicaid daily rate that is:

      i. attributable to depreciation;
      ii. capital related interest;
      iii. rent; and/or
      iv. lease and amortization expenses.

e. **Care Related Cost Component** — the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

f. **Case Mix** — a measure of the intensity of care and services used by similar residents in a facility.

g. **Case Mix Index** — a numerical value that describes the resident's relative resource use within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the department based on the resident's MDS assessment. Two average CMIs will be determined for each facility on a quarterly basis, one using all residents (the facility average CMI) and one using only Medicaid residents (the Medicaid average CMI).

h. **Cost Neutralization** — refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

i. **Delinquent MDS Resident Assessment** — an MDS assessment that is more than 121 days old, as measured by the R2b date field on the MDS.

j. **Direct Care Cost Component** — the portion of the Medicaid daily rate that is attributable to:

   i. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

   ii. a proportionate allocation of allowable employee benefits; and

   iii. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

k. **Facility Cost Report Period Case-Mix Index** — the average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's cost reporting period that is used to determine the medians.

l. **Facility-Wide Average Case-Mix Index** — the simple average, carried to four decimal places, of all resident case-mix indices based on the first day of each calendar quarter.

m. **Index Factor** — will be based on the Skilled Nursing Home without Capital Market Basket Index published by Data Resources Incorporated (DRI-WEFA).

n. **Minimum Data Set (MDS)** — a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the

Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the MDS 2.0 or subsequent revisions as approved by the Center for Medicare and Medicaid Services.

o. **MDS Supportive Documentation Guidelines** — the department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III classification system. These guidelines shall be maintained by the department and updated and published as necessary.

p. **Pass-Through Cost Component** — includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department of Health and Hospitals.

q. **Point-in-Time** — a report that reflects the residents in the facility on the last day of the previous calendar quarter.

r. **Rate Year** — a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates is in effect. It corresponds to a state fiscal year.

s. **Resident-Day-Weighted Median Cost** — a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

t. **RUG-III Resident Classification System** — the resource utilization group used to classify residents. When a resident classifies into more than 1 RUG-III group, the RUG-III group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

u. **Unsupported MDS Resident Assessment** — an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, resident classification system is not supported according to the MDS supporting documentation guidelines and a different RUG-III classification would result in order for the MDS assessment to be considered "unsupported".

2. Rate Determination

a. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price based reimbursement system. Rates shall be calculated from cost report and other statistical data. Effective January 1, 2003, the cost data used in rate setting will be from cost reporting periods ending July 1, 2000 through June 30, 2001. Effective July 1, 2004, and every second year thereafter, the base resident-day-weighted median costs and prices shall be rebased using the most recently audited or desk

reviewed cost reports that are available as of the April 1 prior to the July 1 rate setting. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

b. Each facility's Medicaid daily rate is calculated as:

i. the sum of the facility's direct care and care related price;
ii. the statewide administrative and operating price;
iii. each facility's capital rate component; and
iv. each facility's pass-through rate component.

c. Determination of Rate Components

i. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

(1). The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's direct care per diem cost by the facility cost report period case-mix index.

(2). The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

(3). The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

(4). The statewide direct care and care related price is established at 110 percent of the direct care and care related resident-day-weighted median cost.

(5). The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. The statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the

event that the nursing wage and staffing enhancement add-on is removed. This enhancement is made in accordance with section C.2.d.v.

(6). For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in section C.2.d.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

(7). For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in section C.2.d.i.(3). On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

(8). Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related cost and the direct care and care related floor. If the cost the facility incurred is less than the floor, the facility shall remit to the Bureau the difference between these two amounts times the number of Medicaid days paid during the portion of the cost reporting period after December 31, 2002.

ii. The administrative and operating component of the rate shall be determined as follows.

(1). The per diem administrative and operating cost for each nursing facility is determined by dividing the facility's administrative and operating cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

(2). Each facility's per diem administrative and operating cost is arrayed from low to high and the resident day-weighted median cost is determined.

(3). The statewide administrative and operating price is established at 107.5 percent of the administrative and operating resident-day-weighted median cost.

iii. The capital component of the rate for each facility shall be determined as follows.

(1). The capital cost component rate shall be based on a fair rental value (FRV) reimbursement system. Under a FRV system, a facility is reimbursed on the basis of the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility and its total square footage.

(2). Effective January 1, 2003, the new value per square foot shall be $97.47. This value per square foot shall be increased by $9.75 for land plus an additional $4,000 per licensed bed for equipment. This amount shall be trended forward annually to the midpoint of the rate year using the change in the per diem unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication, adjusted by the weighted average total city cost index for New Orleans, Louisiana. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Subparagraph. A nursing facility's fair rental value per diem is calculated as follows.

(a). Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus $9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. To this value add the product of total licensed beds times $4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent * 30)] of the new bed value. There shall be no recapture of depreciation.

(b). A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's current value times a rental factor. The rental factor shall be the 20-year Treasury Bond Rate as published in

the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk factor of 2.5 percent with an imposed floor of 9.25 percent and a ceiling of 10.75 percent.

(c). The nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 70 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate.

(d). The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years, and to reduce the age for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. If a facility performed a major renovation/replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed), the cost of the renovation project completed during a 24-month period prior to a July 1 rate year will be used to determine the equivalent number of new beds that project represents. The equivalent number of new beds would then be used to determine the weighted average age of all beds for this facility. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation/replacement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation project.

iv. Pass-Through Component of the Rate.

The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The pass through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

Effective January 1, 2003, an add-on amount of $6.27 shall be added to each facility's per diem rate in order to reimburse providers for Medicaid's share of the costs associated with payment of provider fees.

v. Initial Rates.

Effective January 1, 2003, the initial aggregate case mix will be set as recommended by the committee established under Act 694 of the 2001 Regular Session of the Louisiana Legislature at an aggregate rate level not to exceed the old rate methodology aggregate per diem, which was $79.15 on December 31, 2002, and provide incentives for direct care staff. To attain an aggregate case mix per diem of $79.15 on January 1, 2003 and provide incentives for more direct care staff, each facility's capital component will be reduced by $.67, and a nursing wage and staffing enhancement add-on in the amount of $1.26 will be added to each facility's Medicaid daily rate.

3. Case Mix Index Calculation.

   a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.12b case-mix indices developed by the Centers for Medicare and Medicaid Services (CMS) shall be the basis for calculating average case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group will be excluded from the average case-mix index calculation.

   b. Each resident in the facility, with a completed and submitted assessment, shall be assigned a RUG-III 34 group on the first day of each calendar quarter. The RUG-III group is calculated based on the resident's most current assessment, available on the first day of each calendar quarter, and shall be translated to the appropriate case-mix index. From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the first day of each calendar quarter.

   c. The facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payer source on the first day of the calendar quarter.

   d. Verification of Minimum Data Set (MDS) Assessment

      i. The department or its contractor shall provide each nursing facility with a point-in-time preliminary case mix index (CMI) report by approximately the fifteenth day of the second month following the beginning of a calendar quarter. This preliminary report will serve as notice of the MDS assessments transmitted.

      ii. After allowing the facilities a reasonable amount of time (approximately two weeks) to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction policy where applicable, the department or its contractor shall provide each nursing facility with a final CMI report utilizing MDS assessments

      iii. If the department or its contractor determines that a nursing facility has delinquent MDS (minimum data sets) resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case mix index associated with the RUG-III group "BC1-Delinquent". A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III classification system.

      iv. The department or its contractor shall periodically review the MDS supporting documentation maintained by nursing facilities for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department.

fail to reflect the return of such amount on its first Expenditure Report, HCFA Form HCFA-64, submitted following the events described in paragraph c, the State agrees that HCFA shall disallow that amount, pursuant to §1903(d) and subject to 42 CFR 430.48, on the grant award that is based on the Expenditure Report where the return of such funds should have been reflected.

8. Enhancement pool payments to qualifying facilities shall sunset on June 30, 2005. All payments made under this state plan amendment while in effect are valid. The state may submit a state plan amendment after June 30, 2005 that re-implements the above enhancement pool payment methodology or a different methodology.